

**DRAFT Proposed Amendments
Table of Contents**

1.0	Description of Services	1
2.0	Eligible Recipients	1
2.1	General Provisions	1
2.2	Limitations	1
2.3	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age.....	1
3.0	When Services Are Covered	2
3.1	General Criteria.....	2
3.2	Specific Criteria	3
4.0	When Services Are Not Covered	3
4.1	General Criteria.....	3
5.0	Requirements for and Limitations on Coverage	3
5.1	Prior Approval.....	4
5.1.1	Retroactive Prior Approval	4
5.1.2	Denied Prior Approval	4
5.1.3	Voided Prior Approval.....	5
5.2	Submitting a Treatment Plan.....	5
5.3	Procedure Codes and Limitations	5
5.3.1	Diagnostic Procedures.....	6
	Clinical Oral Evaluations	6
	Radiographs/Diagnostic Imaging (including interpretation).....	7
	Requests to Override the Panoramic Film Limitation.....	8
	Oral Pathology Laboratory.....	8
5.3.2	Preventive Procedures.....	9
	Dental Prophylaxis	9
	Topical Fluoride Treatment (office procedure).....	9
	Other Preventive Services	9
	Space Maintenance (passive appliances)	10
5.3.3	Restorative Procedures.....	10
	Amalgam Restorations (including polishing)	10
	Resin-Based Composite Restorations	11
	Prefabricated Crowns.....	11
5.3.4	Endodontic Procedures	12
	Pulpotomy	12
	Root Canal Therapy	13
	Apexification/Recalcification Procedures.....	13
	Apicoectomy/Periradicular Services	14
5.3.5	Periodontal Procedures	14
	Surgical Periodontal Therapy (including usual postoperative care)	14
	Non-Surgical Periodontal Therapy	15
	Other Periodontal Services.....	15

DRAFT Proposed Amendments

5.3.6	Prosthodontic Procedures (removable)	16
	Complete Dentures (including routine post delivery care)	16
	Partial Dentures (including routine post delivery care)	17
	Requests to Override the 10-year Limitation on Complete and Partial Dentures	18
	Adjustments to Dentures	19
	Repairs to Complete Dentures	19
	Repairs to Partial Dentures	19
	Denture Reline Procedures.....	20
5.3.7	Maxillofacial Prosthetics – not covered by Medicaid.....	20
5.3.8	Implant Services – not covered by Medicaid.....	20
5.3.9	Prosthodontic Procedures (fixed).....	20
5.3.10	Oral and Maxillofacial Surgery Procedures	21
	Extractions	21
	Other Surgical Procedures	21
	Alveoloplasty - Surgical Preparation of Ridge for Dentures	22
	Vestibuloplasty	22
	Surgical Excision of Soft Tissue Lesions.....	23
	Surgical Excision of Intra-osseous Lesions	23
	Excision of Bone Tissue	23
	Surgical Incision	24
	Treatment of Fractures – Simple.....	24
	Treatment of Fractures – Compound	24
	Reduction of Dislocation / Management of Other Temporomandibular Joint Dysfunction	25
	Repair of Traumatic Wounds	25
	Complicated Suturing	25
	Other Repair Procedures	26
5.3.11	Adjunctive General Services.....	27
	Unclassified Treatment	27
	Anesthesia	27
	Professional Visits.....	28
	Drugs.....	28
5.3.12	Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations	29
6.0	Providers Eligible to Bill for the Service	30
7.0	Additional Requirements	30
7.1	Nursing Facility and Rest Home Charts.....	30
7.2	Postoperative Care for Residents of Nursing Facilities or Rest Homes.....	30
7.3	Supplement to Dental Prior Approval Form (DMA 6022)	30
7.4	Medicaid Post payment Review	30
7.4	Medical Record Documentation	30

DRAFT Proposed Amendments

8.0	Billing Guidelines	31
8.1	Claim Form	31
8.2	Provider Numbers for Prior-approved Services	31
	8.2.1 Individual Practice	31
	8.2.2 Group Practice.....	31
8.3	Copayment Amounts for Recipients	31
8.4	Billing of Medicaid Recipients	31
8.5	Special Filing Instructions	32
	8.5.1 Procedures Requiring a Tooth Number.....	32
	8.5.2 Supernumerary Teeth.....	32
	8.5.3 Procedures Requiring a Quadrant or Arch Indicator.....	32
	8.5.4 Procedures Requiring a Tooth Surface(s)	32
	8.5.5 Billing for Partial and Complete Dentures.....	32
	8.5.6 Billing for Nondeliverable Partial and Complete Dentures	33
	8.5.7 Billing for Clinic Dental Services	33
	8.5.8 Billing for Hospital Dental Admissions.....	34
	Emergent or Urgent Dental Admissions	34
	Community Care of North Carolina (Carolina ACCESS) Recipients	34
	8.5.9 Billing for Dental Treatment in Ambulatory Surgical Centers (ASC).....	34
	8.5.10 Billing for Assistant Surgeon Fees.....	34
	8.5.11 Billing for Services Covered by Both Medicare and Medicaid	35
9.0	Policy Implementation/Revision Information.....	36
Attachment A:	Dental Billing Guide	38
	A1. Instructions for Filing a Dental Claim	38
	A2. Procedures Requiring a Tooth Number.....	41
	A3. Procedures Requiring a Quadrant or Arch Indicator.....	42
	A4. Procedures Requiring a Tooth Surface(s)	42
	A5. Example of a Completed Dental Claim	43
	A6. Instructions for Submitting a Prior Approval Request.....	44
	A7. Example of a Completed Prior Approval Request	46
	A8. Example of a Voided Prior Approval Request.....	47
	A9. Supplement to Dental Prior Approval Form (DMA 6022)	48
	A10. Billing for Anesthesia Services in an Ambulatory Surgical Center	49
	A11. Billing for Facility Charges by an Ambulatory Surgical Center.....	49
	A12. Billing for Services Covered by Medicare and Medicaid	50

DRAFT Proposed Amendments

1.0 Description of Services

Dental services are defined as diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a recipient's oral or general health. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations hereinafter specified. **Only the procedure codes listed in this policy are covered under the NC Medicaid Dental Program.**

The Division of Medical Assistance (DMA) has adopted procedure codes and descriptions as defined in the most recent edition of *Current Dental Terminology* (CDT-2007/2008). CDT-2007/2008 (including procedure codes, descriptions, and other data) is copyrighted by the American Dental Association. © 2006 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for dental services as described in this policy.

2.2 Limitations

For pregnant Medicaid-eligible recipients with a pink Medicaid identification card, dental services as described in this policy are covered through the day of delivery. Recipients with a blue Medicaid identification card with the program class 'MAFD' and the following statement **"FAMILY PLANNING WAIVER: RECIPIENT ELIGIBLE FOR LIMITED FAMILY PLANNING SERVICES ONLY"** are not eligible for dental services as described in this policy. Refer to **Section 5.3, Procedure Codes and Limitations** for eligibility limitations for individual procedure codes.

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

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Applicable FARS/DFARS apply.

DRAFT Proposed Amendments

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

3.0 When Services Are Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers dental services when the services are medically necessary and

- a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs,
- b. the procedure can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide, and
- c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

DRAFT Proposed Amendments

3.2 Specific Criteria

Necessary and essential dental services, subject to the criteria and limitations listed in this policy, are covered for eligible Medicaid recipients as defined in **Sections 2.0** and **5.3**.

4.0 When Services Are Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care** services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Dental services are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**,
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**,
- c. the procedure duplicates another provider's procedure,
- d. the procedure is experimental, investigational, or part of a clinical trial, or
- e. the criteria specified in this policy have not been met.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care** services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

Only dental materials accepted by the ADA Council on Dental Therapeutics are accepted for use in the dental care of Medicaid recipients. Specific use of these materials must follow the ADA Council on Dental Therapeutics guidelines.

DRAFT Proposed Amendments

5.1 Prior Approval

As indicated in **Section 5.3, Procedure Codes and Limitations**, the provider must submit a written request for prior approval before rendering certain dental services. A prior approval request consists of the following:

- a. A completed two-part 2006 ADA claim form
- b. Properly mounted and dated radiographs that are marked with the name of the recipient and provider

When radiographs cannot be obtained, the provider must include a written explanation and must complete the tooth chart in field 34. Panoramic films must be labeled clearly to indicate the patient's left and right. All radiographs must be of diagnostic quality suitable for interpretation and must be retained in the recipient's record for a minimum of five years for the purpose of Medicaid post-payment review. Prior approval requests must be sent to

EDS Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

Prior approval is valid for one year from the approval date, but prior approval does not guarantee payment. Recipient eligibility for the date of service must be verified before rendering treatment. Failure to obtain required prior approval before rendering a service will result in denial of payment for that service. The Medicaid program has the right to require prior approval for any services by providers who have been or are under investigation by DMA. Refer to **Attachment A – Dental Billing Guide** for an example of a prior approval request.

5.1.1 Retroactive Prior Approval

Prior approval may be granted retroactively in cases of retroactive Medicaid eligibility or when the recipient's condition prevents pretreatment oral evaluation and services are rendered in an inpatient hospital, outpatient hospital or ambulatory surgical center, as indicated in field 38 on the prior approval form.

5.1.2 Denied Prior Approval

Typically, prior approval for a procedure is denied for one of the following reasons:

- a. The recipient already has received the procedure within the time limit described in **Section 5.3, Procedure Codes and Limitations**.
- b. The procedure does not meet the limitations described in **Section 5.3, Procedure Codes and Limitations**.
- c. The procedure is not covered by the Medicaid program.

If a procedure is denied for a reason other than one of the above, an explanation will be written in field 35 on the prior approval request form.

DRAFT Proposed Amendments

5.1.3 Voided Prior Approval

In certain circumstances, a provider may need to void a prior approval. This is necessary in cases where

- the recipient's treatment plan has changed significantly,
- the prior approval period has expired before the service could be rendered, or
- the recipient wishes to have the service rendered by another provider.

In such cases, the provider must submit the prior approval request marked "**VOID**" to either the EDS Prior Approval Unit or to the recipient's new dentist, if applicable. Refer to **Attachment A – Dental Billing Guide** for an example of a voided prior approval request.

5.2 Submitting a Treatment Plan

For prior approval involving complex cases, a dentist may choose to submit for consultant review an entire treatment plan consisting of

- one or more two-part 2006 ADA claim forms documenting the planned procedures,
- mounted and labeled radiographs stapled to the claim form(s), and
- any additional information to clarify unusual circumstances or explain the complexity of the treatment plan.

One procedure code per line should be listed on the claim form with a maximum of 10 codes per form. Fees **must not** be listed because prior approval applies only to procedures and not to reimbursement amounts. Treatment plans are submitted to the EDS Prior Approval Unit.

5.3 Procedure Codes and Limitations

By State legislative authority, DMA applies service limitations to ADA procedure codes as they relate to individual recipients. These service limitations are applied without modification of the ADA procedure description. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (*) beneath the description of that code. Claims for services that fall outside these limitations will be denied unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21. Refer to **Section 5.3.12, Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations**.

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5.3.1 Diagnostic Procedures

Clinical Oral Evaluations

A provider may bill for only one clinical oral evaluation procedure for an individual recipient on a given date of service.

Code	Description	PA Needed?
D0120	Periodic oral evaluation * the first periodic oral evaluation must be at least six (6) calendar months after the comprehensive oral evaluation (D0150) or at least six (6) calendar months after an oral evaluation for a patient under three years of age (D0145) for the same provider.	No

DRAFT Proposed Amendments

	<ul style="list-style-type: none"> * allowed once per six (6) calendar month period for the same provider (For example, a patient seen for a periodic oral evaluation exam on any date in January would be eligible for the next periodic oral evaluation on any date in July.) 	
D0140	<p>Limited oral evaluation – problem-focused</p> <ul style="list-style-type: none"> * use as the emergency exam for the first visit for a specific problem; follow-up evaluations for the same problem must be coded as D0170 * document in the patient’s chart the nature of the emergency and the treatment provided 	No
D0145	<p>Oral evaluation for a patient under three years of age and counseling with primary caregiver</p> <ul style="list-style-type: none"> * evaluation includes recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen, and communication with and counseling of the child’s parent, legal guardian and/or primary caregiver * the first oral evaluation for a patient under three years of age must be at least six (6) calendar months after the comprehensive oral evaluation (D0150) or at least six (6) calendar months after a periodic oral evaluation (D0120) for the same provider * allowed once per six (6) calendar month period for the same provider (For example, a patient seen for an oral evaluation for a patient under three years of age on any date in January would be eligible for the next oral evaluation for a patient under three years of age on any date in July.) * allowed on recipients under age 3 * service must be provided in conjunction with topical fluoride varnish (1206) 	No
D0150	<p>Comprehensive oral evaluation – new or established patient</p> <ul style="list-style-type: none"> * use as the initial exam for a recipient * allowed as an initial exam once per provider per recipient 	No
D0160	<p>Detailed and extensive oral evaluation - problem-focused, by report</p> <ul style="list-style-type: none"> * entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation * requires integration of extensive diagnostic modalities to develop a treatment plan for a specific problem * condition requiring this type of evaluation should be described and documented * examples include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, and systemic diseases requiring multidisciplinary consultation * not allowed as a routine office visit or for orthodontic records 	No
D0170	<p>Re-evaluation – limited, problem focused</p> <ul style="list-style-type: none"> * use as a follow-up exam for a specific problem that has been evaluated previously using D0140 * document in the patient’s chart the nature of the emergency and the treatment provided 	No

DRAFT Proposed Amendments

Radiographs/Diagnostic Imaging (including interpretation)

Code	Description	PA Needed?
D0210	Intraoral - complete series (including bitewings) * allowed one (1) time per five (5) years * not allowed on the same date of service as D0330 * any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service, which exceeds the maximum allowed fee for D0210, will be reimbursed at the same fee as D0210 * panoramic film and bitewing films taken on the same date of service should not be billed as a D0210	No
D0220	Intraoral - periapical - first film * only one (1) allowed per day for an individual recipient for the same provider * not allowed on the same date of service as D0210	No
D0230	Intraoral - periapical - each additional film * more than eight (8) additional periapical films should be billed as a D0210 * not allowed on the same date of service as D0210	No
D0240	Intraoral - occlusal film	No
D0250	Extraoral - first film	No
D0260	Extraoral - each additional film	No
D0270	Bitewing - single film * allowed one (1) time per 12 calendar month period * not allowed on same date of service as D0272, D0273, or D0274 * not allowed within the same 12 calendar month period as D0210	No
D0272	Bitewings - two films * allowed one (1) time per 12 calendar month period * not allowed on same date of service as D0270, D0273, or D0274 * not allowed within the same 12 calendar month period as D0210	No
D0273	Bitewings - three films * allowed one (1) time per 12 calendar month period * not allowed on same date of service as D0270, D0272, or D0274 * not allowed within the same 12 calendar month period as D0210	No
D0274	Bitewings - four films * limited to recipients 13 years and older * allowed one (1) time per 12 calendar month period * not allowed on same date of service as D0270, D0272, or D0273 * not allowed within the same 12 calendar month period as D0210	No

DRAFT Proposed Amendments

Radiographs/Diagnostic Imaging, continued

Code	Description	PA Needed?
D0290	Posterior-anterior or lateral skull and facial bone survey film	No
D0310	Sialography	No
D0320	Temporomandibular joint arthrogram, including injection	No
D0330	Panoramic film * allowed one (1) time per five (5) years * not allowed on the same date of service as D0210	No

Requests to Override the Panoramic Film Limitation

An override of the 5-year limitation on panoramic films will be considered **only** under the following exceptional circumstances:

- The provider finds clinical or radiographic evidence of **new** oral disease or a **new** problem that cannot be evaluated adequately using any other type of radiograph, or
- The recipient's previous provider is unable or unwilling to provide a copy of the previous panoramic film that is of diagnostic quality. (Such cases may result in recoupment of Medicaid's payment for the previous film.)

To request a panoramic override, the provider must submit the following:

- A properly completed 2006 ADA claim form,
- Copies of the current and previous panoramic films as well as any other radiographs that support the override request, and
- A cover letter that clearly describes the circumstances of the case.

These requests should be mailed to

EDS Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

Oral Pathology Laboratory

Code	Description	PA Needed?
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report * use for lab reporting fee	No

DRAFT Proposed Amendments

5.3.2 Preventive Procedures

Dental Prophylaxis

Dental prophylaxis (D1110 or D1120) is allowed once per recipient per six (6) calendar month period for the same provider. (For example, a patient seen for a prophylaxis on any date in January would be eligible for the next prophylaxis on any date in July.)

Dental prophylaxis (D1110 or D1120) is not allowed for an individual recipient on the same date of service as a periodontal procedure (D4210, D4211, D4240, D4241, D4341, D4342, D4355 or D4910).

Code	Description	PA Needed?
D1110	Prophylaxis – adult * limited to recipients 13 years and older	No
D1120	Prophylaxis - child * limited to recipients under 13 years old	No

Topical Fluoride Treatment (office procedure)

Topical fluoride treatment (D1203, D1204 or D1206) is allowed once per recipient per six (6) calendar month period for the same provider. (For example, a patient seen for a topical fluoride treatment on any date in January would be eligible for the next topical fluoride treatment on any date in July.) Topical fluoride **must** be applied to **all** teeth erupted on the date of service.

Code	Description	PA Needed?
D1203	Topical application of fluoride (prophylaxis not included) – child * limited to recipients under 13 years old	No
D1204	Topical application of fluoride (prophylaxis not included) – adult * limited to recipients 13 through 20 years old	No
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients * limited to recipients under age 21	No

Other Preventive Services

Code	Description	PA Needed?
D1351	Sealant - per tooth * covered for permanent first and second molars and premolars for recipients under age 21 * covered for primary molars for recipients under age 10 (For children 10 through 20 with special needs, refer to Section 5.3.12 for special approval requirements.) * teeth to be sealed must have pits and fissures that are susceptible to caries * teeth to be sealed must be free of proximal caries and free of restorations on the surface to be sealed * teeth should be sealed after being identified at high risk for decay * allowed once in a lifetime per tooth	No

DRAFT Proposed Amendments

Space Maintenance (passive appliances)

All necessary preparation of the oral cavity for proper insertion of appliances must be completed prior to insertion.

Code	Description	PA Needed?
D1510	Space maintainer - fixed – unilateral * includes band and loop, crown and loop, or distal shoe * limited to recipients under age 21 * limited to replacement of primary molars and canines and permanent first molars * requires a quadrant indicator in the area of oral cavity or tooth number field * use delivery date as date of service when requesting payment	No
D1515	Space maintainer - fixed – bilateral * limited to recipients under age 21 * limited to replacement of primary molars and canines and permanent first molars * requires an arch indicator (UP, LO) in the area of oral cavity or tooth number field * bill D6985 when appliance is to serve as a fixed pediatric partial denture to replace maxillary anterior teeth * use delivery date as date of service when requesting payment	No

5.3.3 Restorative Procedures

Each surface on the same tooth is covered only once per date of service. Connecting or adjoining surfaces must be billed under one procedure code. Payment for the restoration includes local anesthesia and any necessary liners and/or bases. Primary tooth restorations are not allowed when normal exfoliation is imminent.

Amalgam Restorations (including polishing)

Code	Description	PA Needed?
D2140	Amalgam - one surface, primary or permanent	No
D2150	Amalgam - two surfaces, primary or permanent	No
D2160	Amalgam - three surfaces, primary or permanent	No
D2161	Amalgam - four or more surfaces, primary or permanent * not allowed on the same date of service as D2950 for the same tooth	No

DRAFT Proposed Amendments

Resin-Based Composite Restorations

Resin-based composite restorations are allowed to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Resin-based composite restorations are not covered as a preventive procedure and are not covered for treatment of cosmetic problems (e.g., diastemas, discolored teeth, developmental anomalies).

Code	Description	PA Needed?
D2330	Resin-based composite - one surface, anterior	No
D2331	Resin-based composite - two surfaces, anterior	No
D2332	Resin-based composite - three surfaces, anterior	No
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) * not allowed on the same date of service as D2950 for the same tooth	No
D2390	Resin-based composite crown – anterior * allowed for primary anterior teeth only	No
D2391	Resin-based composite – one surface, posterior	No
D2392	Resin-based composite – two surfaces, posterior	No
D2393	Resin-based composite – three surfaces, posterior * allowed for permanent posterior teeth only	No
D2394	Resin-based composite – four or more surfaces, posterior * allowed for permanent posterior teeth only * not allowed on the same date of service as D2950 for the same tooth	No

Other Restorative Services

Prefabricated Crowns

Code	Description	PA Needed?
D2930	Prefabricated stainless steel crown - primary tooth * limited to recipients under age 21	No
D2931	Prefabricated stainless steel crown - permanent tooth * limited to recipients under age 21 * limited to permanent premolars and first and second molars	No
D2932	Prefabricated resin crown * limited to recipients under age 21 * limited to primary and permanent anterior teeth	No
D2933	Prefabricated stainless steel crown with resin window * limited to recipients under age 21 * limited to primary anterior teeth	No
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth * limited to recipients under age 21 * limited to primary anterior teeth	No

DRAFT Proposed Amendments

Prefabricated Crowns, continued

NC Medicaid will pay for a maximum of six (6) crowns per recipient for a single date of service.

- This limitation applies to procedure codes D2390, D2930, D2931, D2932, D2933, D2934, and D2970 or to any combination of these codes delivered on the same date of service.
- This limitation **does not** apply to recipients treated under general anesthesia in a hospital or ambulatory surgery center.
- If a provider believes that medical necessity warrants delivery of more than six (6) crowns for a recipient on a single date of service, the provider must submit a prior approval request along with a letter describing the special circumstances of the case. (Refer to **Section 5.1, Prior Approval** for specific instructions on submitting a prior approval request.)

Code	Description	PA Needed?
D2940	Sedative filling	No
D2950	Core buildup, including any pins * not allowed on the same date of service as D2161, D2335, D2394, or D2951 for the same tooth	No
D2951	Pin retention - per tooth, in addition to restoration * not allowed on the same date of service as D2950 for the same tooth	No
D2970	Temporary crown (fractured tooth) * limited to recipients under age 21	No

5.3.4 Endodontic Procedures

Pulpotomy

Code	Description	PA Needed?
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament * not allowed for the same tooth on the same date of service as D3230, D3240, D3310, D3320 or D3330	No

NC Medicaid will pay for a maximum of six (6) pulpomies per recipient for a single date of service.

- This limitation applies to procedure code D3220.
- This limitation **does not** apply to recipients treated under general anesthesia in a hospital or ambulatory surgical center.
- If a provider believes that medical necessity warrants delivery of more than six (6) pulpomies for a recipient on a single date of service, the provider must submit a prior approval request along with a letter describing the special circumstances of the case. (Refer to **Section 5.1, Prior Approval** for specific instructions on submitting a prior approval request.)

DRAFT Proposed Amendments

Root Canal Therapy

Intra-operative radiographs taken during root canal therapy must be included as part of the procedure and must not be billed separately. Radiographs taken for diagnostic purposes may be billed separately, as needed. Postoperative radiographs **must** be maintained in the recipient record.

Primary Teeth

Code	Description	PA Needed?
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) * limited to recipients under age 6 * not allowed for the same tooth on the same date of service as D3220	No
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) * limited to recipients under age 9 * allowed for primary second molars only * not allowed for the same tooth on the same date of service as D3220	No

Permanent Teeth

Code	Description	PA Needed?
D3310	Anterior (excluding final restoration) * permanent anterior teeth only * not allowed for the same tooth on the same date of service as D3220	No
D3320	Bicuspid (excluding final restoration) * limited to recipients under age 21 * not allowed for the same tooth on the same date of service as D3220	No
D3330	Molar (excluding final restoration) * limited to recipients under age 21 * limited to permanent first and second molars * not allowed for the same tooth on the same date of service as D3220	No

Apexification/Recalcification Procedures

Code	Description	PA Needed?
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) * allowed four (4) times per year	No
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	No

DRAFT Proposed Amendments

Apicoectomy/Periradicular Services

Code	Description	PA Needed?
D3410	Apicoectomy/periradicular surgery - anterior	No

5.3.5 Periodontal Procedures

Any combination of prophylaxis (D1110 or D1120) or periodontal procedures (D4210, D4211, D4240, D4241, D4341, D4342, D4355 or D4910) is not allowed on the same date of service for a recipient.

Surgical Periodontal Therapy (including usual postoperative care)

Code	Description	PA Needed?
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant * includes scaling and root planing * allowed once in a lifetime * requires pretreatment narrative documenting underlying medical condition * requires periodontal charting (pocket depth measurements must be abnormal) * requires a quadrant indicator in the area of oral cavity or tooth number field * not allowed for the same quadrant as D4211, D4240, D4241, D4341 or D4342 on the same date of service	Yes
D4211	Gingivectomy or gingivoplasty – one to three teeth contiguous teeth or bounded teeth spaces per quadrant * includes scaling and root planing * allowed once in a lifetime * requires pretreatment narrative documenting underlying medical condition * requires periodontal charting (pocket depth measurements must be abnormal) * requires a quadrant indicator in the area of oral cavity or tooth number field * not allowed for the same quadrant as D4210, D4240, D4241, D4341 or D4342 on the same date of service	Yes
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant * allowed once in a lifetime * requires pretreatment narrative documenting underlying medical condition * requires periodontal charting (pocket depth measurements must be abnormal) * requires a quadrant indicator in the area of oral cavity or tooth number field * not allowed for the same quadrant as D4210, D4211, D4241, D4341 or D4342 on the same date of service	Yes

DRAFT Proposed Amendments

Surgical Periodontal Therapy, continued

Code	Description	PA Needed?
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant <ul style="list-style-type: none"> * allowed once in a lifetime * requires pretreatment narrative documenting underlying medical condition * requires periodontal charting (pocket depth measurements must be abnormal) * requires a quadrant indicator in the area of oral cavity or tooth number field * not allowed for the same quadrant as D4210, D4211, D4240, D4341 or D4342 on the same date of service 	Yes

Non-Surgical Periodontal Therapy

Code	Description	PA Needed?
D4341	Periodontal scaling and root planing – four or more teeth per quadrant <ul style="list-style-type: none"> * each quadrant is allowed one (1) time per 12-month interval * requires a quadrant indicator in the area of oral cavity or tooth number field * not allowed for the same quadrant as D4210, D4211, D4240, D4241 or D4342 on the same date of service 	Yes
D4342	Periodontal scaling and root planing – one to three teeth per quadrant <ul style="list-style-type: none"> * each quadrant is allowed one (1) time per 12-month interval * requires a quadrant indicator in the area of the oral cavity or tooth number field * not allowed for the same quadrant as D4210, D4211, D4240, D4241 or D4341 on the same date of service 	Yes
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis <ul style="list-style-type: none"> * allowed one (1) time per 12-month interval * not allowed on same date of service as D1110, D1120, D4210, D4211, D4240, D4241, D4341, D4342 or D4910 	No

Other Periodontal Services

Code	Description	PA Needed?
D4910	Periodontal maintenance <ul style="list-style-type: none"> * allowed only if D4210, D4211, D4240 or D4241 precedes this treatment * allowed two (2) times per year * procedure may be alternated with D1110 * not allowed on same date of service as D1110, D1120, D4210, D4211, D4240, D4241, D4341, D4342 or D4355 	No

DRAFT Proposed Amendments

5.3.6 Prosthodontic Procedures (removable)

Appliances **will not** be authorized when a recipient's dental history indicates negligence in the proper care of appliances or physiological or psychological problems that have caused previous dentures to be unsatisfactory. Appliances will not be authorized when repair or reline would make existing appliances serviceable. Appliances will not be authorized when the appliances are lost by the recipient, hospital, or nursing home.

Complete Dentures (including routine post delivery care)

Only one (1) denture (complete or immediate) is allowed per arch every ten (10) years.

Medicaid does not cover temporary or interim dentures. Codes D5110 and D5120 should be used for overdentures. All necessary preparation of the oral cavity must be complete prior to denture delivery. Hand delivery of an appliance to a recipient does not constitute delivery of an appliance. Immediate dentures delivered by another provider should be forwarded directly to that provider. **Providers must use date of delivery as the date of service when requesting payment for a denture.** Payment for complete dentures (D5110 and D5120) includes any adjustments or relines necessary for six (6) months after the date of delivery.

Code	Description	PA Needed?
D5110	Complete denture – maxillary	Yes
D5120	Complete denture – mandibular	Yes
D5130	Immediate denture – maxillary	Yes
D5140	Immediate denture – mandibular	Yes

Note: Radiographs **are not required** when requesting prior approval for complete denture(s).

Note: When requesting prior approval for an immediate denture, the provider also should request prior approval for the appropriate denture reline at the same time (see note on p. 20).

Note: Every prior approval request for fabrication of a denture (impression, try-in, or delivery) to be rendered in a nursing facility or rest home must be accompanied by a Supplement to Dental Prior Approval form (DMA 6022). Refer to **Section 7.3, Supplement to Dental Prior Approval Form** and to **Attachment A – Dental Billing Guide** for additional information.

DRAFT Proposed Amendments

Partial Dentures (including routine post delivery care)

Only one (1) partial denture is allowed per arch every ten (10) years. Medicaid does not cover temporary or interim dentures or unilateral partial dentures. All necessary preparation of the oral cavity must be complete prior to denture delivery. Hand delivery of an appliance to a recipient does not constitute delivery of an appliance. Partial dentures delivered by another provider (ex. -- immediate partial denture) should be forwarded directly to that provider.

Providers must use date of delivery as the date of service when requesting payment for a denture. Payment includes any adjustments or relines necessary for six (6) months after the date of delivery.

Partial dentures will be authorized **only** under the following criteria:

For recipients under age 21	For recipients age 21 and older
<ul style="list-style-type: none"> any missing anterior teeth (incisors or canines) two missing first molars in an arch three (3) missing posterior permanent teeth in an arch two (2) adjacent missing posterior permanent teeth in an arch 	<ul style="list-style-type: none"> any missing anterior teeth (incisors or canines) four (4) missing posterior permanent teeth in an arch three (3) adjacent missing posterior permanent teeth in an arch

Note: Missing third molars do not count when determining Medicaid coverage for a partial denture. Appliances will not be authorized when radiographs show substantial space closure after tooth loss due to tooth migration preventing replacement of the missing tooth. The provider must document mobility, pocket depth, presence of inflammation and prognosis for periodontially compromised abutment teeth. The provider also must indicate whether it would be possible to add teeth to the partial or convert it to a complete denture if the compromised abutment teeth are lost.

Code	Description	PA Needed?
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	Yes
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	Yes
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Yes
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Yes

DRAFT Proposed Amendments

Requests to Override the 10-year Limitation on Complete and Partial Dentures

An override of the 10-year limitation on a complete or partial denture will be considered **only** in the following exceptional circumstances:

- a. Dentures were stolen
requires a copy of the police report
- b. Dentures were lost in a house fire
requires a copy of the fire report
- c. Dentures were lost in a hurricane, flood or other natural disaster
requires a copy of documentation from FEMA or the American Red Cross indicating loss of possessions
- d. Dentures no longer fit due to a significant medical condition
requires a letter from the recipient's physician or surgeon documenting the medical condition and a letter from the recipient's dentist stating that the existing denture cannot be made functional by adjusting or relining it and that a new denture is likely to be functional

To request an override, the provider must submit the following:

- a. A properly completed 2006 ADA claim form clearly marked **"Request for Denture Override"**
- b. Copies of current radiographs when requesting an override for a partial denture
- c. Any supporting documentation listed above, as applicable
- d. A cover letter that clearly describes the circumstances of the case

These requests must be mailed to

EDS Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

DRAFT Proposed Amendments

Adjustments to Dentures

Adjustments to complete or partial dentures are reimbursable beginning six (6) months after delivery of the appliances.

Code	Description	PA Needed?
D5410	Adjust complete denture – maxillary	No
D5411	Adjust complete denture - mandibular	No
D5421	Adjust partial denture - maxillary	No
D5422	Adjust partial denture - mandibular	No

Repairs to Complete Dentures

If multiple repairs are made to one appliance on the same date of service, the first repair will be reimbursed at 100% of the maximum allowed rate and subsequent repairs at 35% of the maximum allowed rate.

Code	Description	PA Needed?
D5510	Repair broken complete denture base * requires an arch indicator (UP, LO) in the area of oral cavity or tooth number field	No
D5520	Replace missing or broken teeth – complete denture (each tooth) * requires a tooth number in the tooth number field	No

Repairs to Partial Dentures

For multiple repairs made to one appliance on the same date of service, the first repair will be paid at 100% of the maximum rate and subsequent repairs at 35% of the maximum rate.

Code	Description	PA Needed?
D5610	Repair resin denture base * requires an arch indicator (UP, LO) in the area of the oral cavity or tooth number field	No
D5620	Repair cast framework * requires an arch indicator (UP, LO) in the area of oral cavity or tooth number field	No
D5630	Repair or replace broken clasp * requires a tooth number in the tooth number field	No
D5640	Replace broken teeth - per tooth * requires a tooth number in the tooth number field	No
D5650	Add tooth to existing partial denture * requires a tooth number in the tooth number field	No
D5660	Add clasp to existing partial denture * requires a tooth number in the tooth number field	No

DRAFT Proposed Amendments

Denture Reline Procedures

Billing for the initial reline of a complete or partial denture is allowed beginning six (6) months after the date of delivery of the denture. Subsequent relines are allowed one (1) time every five (5) years. Medicaid does not cover tissue conditioning, soft relines or rebase procedures.

Note: For an immediate denture (D5130 or D5140), the initial reline may be billed sooner than six-months from denture delivery if the provider determines that healing of extraction sites is essentially complete and a reline is necessary to assure proper fit and function of the denture. Subsequent relines are allowed one (1) time every five (5) years.

Code	Description	PA Needed?
D5730	Reline complete maxillary denture (chairside)	Yes
D5731	Reline complete mandibular denture (chairside)	Yes
D5740	Reline maxillary partial denture (chairside)	Yes
D5741	Reline mandibular partial denture (chairside)	Yes
D5750	Reline complete maxillary denture (laboratory)	Yes
D5751	Reline complete mandibular denture (laboratory)	Yes
D5760	Reline maxillary partial denture (laboratory)	Yes
D5761	Reline mandibular partial denture (laboratory)	Yes

5.3.7 Maxillofacial Prosthetics – not covered by Medicaid

5.3.8 Implant Services – not covered by Medicaid

5.3.9 Prosthodontic Procedures (fixed)

Code	Description	PA Needed?
D6985	Pediatric partial denture, fixed * limited to recipients under age 6	No

DRAFT Proposed Amendments

5.3.10 Oral and Maxillofacial Surgery Procedures

Extractions

Payment for an extraction includes local anesthesia, any necessary sutures, and routine postoperative care. Primary tooth extractions are not allowed when normal exfoliation is imminent.

Code	Description	PA Needed?
D7111	Extraction, coronal remnants – deciduous tooth	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No
D7220	Removal of impacted tooth - soft tissue	No
D7230	Removal of impacted tooth - partially bony	No
D7240	Removal of impacted tooth - completely bony	No
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications * requires documentation of clinical or radiographic conditions that qualify the extraction as unusually complicated (e.g., full impaction requiring multisectioning of the tooth, full impaction high in the maxillary sinus area or low in the mandibular canal area, full vertical or horizontal impaction)	No
D7250	Surgical removal of residual tooth roots (cutting procedure)	No

Other Surgical Procedures

Code	Description	PA Needed?
D7260	Oroantral fistula closure	No
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	No
D7280	Surgical access of an unerupted tooth * not allowed on the same date of service as an extraction for the same tooth	No
D7283	Placement of device to facilitate eruption of impacted tooth * report the surgical exposure separately using D7280 * not allowed on the same date of service as an extraction for the same tooth	No
D7285	Biopsy of oral tissue – hard (bone, tooth)	No
D7286	Biopsy of oral tissue – soft	No
D7288	Brush biopsy – transepithelial sample collection	No

DRAFT Proposed Amendments

Alveoloplasty - Surgical Preparation of Ridge for Dentures

Code	Description	PA Needed?
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant * requires a quadrant indicator in the area of oral cavity or tooth number field	No
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant * must be three edentulous units in a quadrant to qualify for payment for alveoloplasty * requires a quadrant indicator in the area of oral cavity or tooth number field	No
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant * requires a quadrant indicator in the area of oral cavity or tooth number field	Yes
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant * must be three edentulous units in a quadrant to qualify for payment for alveoloplasty * requires a quadrant indicator in the area of oral cavity or tooth number field	Yes

Vestibuloplasty

Code	Description	PA Needed?
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) * requires an arch indicator (UP, LO) in the area of oral cavity or tooth number field	Yes
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle attachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue) * document the exact procedure to be performed and the estimated fee * requires an arch indicator (UP, LO) in the area of oral cavity or tooth number field	Yes

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Surgical Excision of Soft Tissue Lesions

Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7410	Excision of benign lesion up to 1.25 cm	No
D7411	Excision of benign lesion greater than 1.25 cm	No
D7412	Excision of benign lesion, complicated	No
D7413	Excision of malignant lesion up to 1.25 cm	No
D7414	Excision of malignant lesion greater than 1.25 cm	No
D7415	Excision of malignant lesion, complicated	No
D7465	Destruction of lesion(s) by physical or chemical method, by report	No

Surgical Excision of Intra-osseous Lesions

Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	No
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	No
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	No
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No

Excision of Bone Tissue

Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7471	Removal of lateral exostosis (maxilla or mandible) * allowed as an arch procedure * requires an arch indicator (UP, LO) in the area of oral cavity or tooth number field	No
D7472	Removal of torus palatinus * allowed as an upper arch procedure	No
D7473	Removal of torus mandibularis * allowed as a lower arch procedure	No
D7485	Surgical reduction of osseous tuberosity	No
D7490	Radical resection of maxilla or mandible	No

DRAFT Proposed Amendments

Surgical Incision

Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7510	Incision and drainage of abscess - intraoral soft tissue * involves incision through mucosa; document area of incision * not allowed in the same site as a surgical tooth extraction	No
D7520	Incision and drainage of abscess - extraoral soft tissue * document the area of the incision	No
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue * use for removal of bony spicules	No
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system	No
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	No
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	No

Treatment of Fractures - Simple

Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7610	Maxilla - open reduction (teeth immobilized, if present)	No
D7620	Maxilla - closed reduction (teeth immobilized, if present)	No
D7630	Mandible - open reduction (teeth immobilized, if present)	No
D7640	Mandible - closed reduction (teeth immobilized, if present)	No
D7650	Malar and/or zygomatic arch - open reduction	No
D7660	Malar and/or zygomatic arch - closed reduction	No
D7670	Alveolus – closed reduction, may include stabilization of teeth	No
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	No

Treatment of Fractures - Compound

Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7710	Maxilla - open reduction	No
D7720	Maxilla - closed reduction	No
D7730	Mandible - open reduction	No
D7740	Mandible - closed reduction	No
D7750	Malar and/or zygomatic arch - open reduction	No
D7760	Malar and/or zygomatic arch - closed reduction	No
D7770	Alveolus – open reduction stabilization of teeth	No
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	No

DRAFT Proposed Amendments

Reduction of Dislocation / Management of Other Temporomandibular Joint Dysfunction

For prior approval, include a narrative documenting medical necessity. Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7810	Open reduction of dislocation * not allowed on same date of service as D7873	No
D7820	Closed reduction of dislocation * not allowed on same date of service as D7873	No
D7830	Manipulation under anesthesia * not allowed on same date of service as D7873	Yes
D7840	Condylectomy * not allowed on same date of service as D7873	No
D7850	Surgical discectomy, with/without implant * not allowed on same date of service as D7858, D7865 or D7873	No
D7858	Joint reconstruction * not allowed on same date of service as D7850, D7860 or D7873	Yes
D7860	Arthrotomy * not allowed on same date of service as D7858, D7865 or D7873	No
D7865	Arthroplasty * not allowed on same date of service as D7850, D7860 or D7873	Yes
D7870	Arthrocentesis	No
D7872	Arthroscopy – diagnosis, with or without biopsy * not allowed on same date of service as D7873	No
D7873	Arthroscopy – surgical: lavage and lysis of adhesions * not allowed on same date of service as D7810, D7820, D7830, D7840, D7850, D7858, D7860, D7865 or D7872	No

Repair of Traumatic Wounds

Code	Description	PA Needed?
D7910	Suture of recent small wounds up to 5 cm * used exclusively for injuries * not allowed for extraction or periodontal surgery sites	No

Complicated Suturing

Code	Description	PA Needed?
D7911	Complicated suture - up to 5 cm * used exclusively for injuries * not allowed for extraction or periodontal surgery sites	No
D7912	Complicated suture - greater than 5 cm * used exclusively for injuries * not allowed for extraction or periodontal surgery sites	No

DRAFT Proposed Amendments

Other Repair Procedures

Certain second surgeries (e.g., bilateral procedures) performed on the same date of service may be reimbursed at 50% of the maximum allowed rate.

Code	Description	PA Needed?
D7920	Skin grafts (identify defect covered, location and type of graft) * document the exact procedure to be performed and the estimated fee * not allowed to correct periodontal problems	Yes
D7940	Osteoplasty – for orthognathic deformities	Yes
D7941	Osteotomy – mandibular rami	Yes
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	Yes
D7944	Osteotomy – segmented or subapical	Yes
D7945	Osteotomy – body of mandible	Yes
D7946	LeFort I (maxilla – total)	Yes
D7947	LeFort I (maxilla – segmented)	Yes
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Yes
D7949	LeFort II or LeFort III – with bone graft	Yes
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Yes
D7955	Repair of maxillofacial soft and/or hard tissue defect	Yes
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure * document necessity (e.g., impairing speech, hindering mastication, prevents seating denture)	Yes
D7963	Frenuloplasty * document necessity (e.g., impairing speech, hindering mastication, prevents seating denture)	Yes
D7971	Excision of pericoronal gingiva * use for operculectomy * not allowed on the same date of service as an extraction for the same tooth * not allowed for crown lengthening or gingivectomy * requires a tooth number in the tooth number field	No
D7972	Surgical reduction of fibrous tuberosity	No
D7980	Sialolithotomy	Yes
D7981	Excision of salivary gland, by report	Yes
D7982	Sialodochoplasty	Yes
D7983	Closure of salivary fistula	Yes
D7990	Emergency tracheotomy	No
D7991	Coronoidectomy	No

DRAFT Proposed Amendments

5.3.11 Adjunctive General Services

Unclassified Treatment

Code	Description	PA Needed?
D9110	Palliative (emergency) treatment of dental pain – minor procedure <ul style="list-style-type: none"> * use for minor dental procedures to relieve dental/oral pain * document in the patient's chart the nature of the emergency and the specific treatment provided * not allowed for writing prescriptions, dispensing drugs or medicaments through the office or administering drugs orally 	No

Anesthesia

The administration of local anesthesia is considered part of a procedure and no additional fee is allowed. Medicaid does not cover acupuncture, hypnosis, or other non-pharmacologic methods.

Code	Description	PA Needed?
D9220	Deep sedation/general anesthesia - first 30 minutes <ul style="list-style-type: none"> * allowed once per date of service * allowed only in an office setting * deep sedation/general anesthesia performed in the dental office must include documentation in the record of pharmacologic agents, monitoring of vital signs, and complete sedation/general anesthesia time * reimbursement includes all drugs and/or medicaments necessary for adequate deep sedation/general anesthesia * reimbursement includes monitoring and management 	No
D9221	Deep sedation/general anesthesia - each additional 15 minutes <ul style="list-style-type: none"> * allowed only in an office setting * allowed up to a total of six hours of sedation/general anesthesia time 	No
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide <ul style="list-style-type: none"> * reimbursement includes monitoring and management 	No
D9241	Intravenous conscious sedation/analgesia - first 30 minutes <ul style="list-style-type: none"> * allowed once per date of service * allowed only in an office setting * intravenous conscious sedation performed in the dental office must include documentation in the record of pharmacologic agents, IV site, monitoring of vital signs, and complete anesthesia time * reimbursement includes all drugs and/or medicaments necessary for adequate anesthesia * reimbursement includes monitoring and management 	No
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes <ul style="list-style-type: none"> * allowed only in an office setting * allowed up to a total of six (6) hours of anesthesia time 	No

DRAFT Proposed Amendments

Professional Visits

Code	Description	PA Needed?
D9410	House/extended care facility call * a dentist can be reimbursed for only one house call per date of service per facility regardless of the number of recipients seen on that day	No
D9420	Hospital call * one (1) visit per surgery * necessity of hospitalization should be documented on paper claims or in the record if billing electronically * submit operative notes with the paper claim or maintain in the record if billing electronically * hospitalization does not require admission pre-certification * Community Care of North Carolina (Carolina ACCESS) recipients require referral from their primary care physician for hospital admission	No
D9440	Office visit - after regularly scheduled hours	No

Drugs

Code	Description	PA Needed?
D9610	Therapeutic parenteral drug, single administration * allowed for a single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications * not allowed for the administration of sedatives, anesthetic, or reversal agents * identify drug, dosage and rationale in the recipient's dental record and on the claim form if filed as a paper claim	No
D9630	Other drugs and/or medicaments, by report * use <u>only</u> for antibiotics and/or steroids administered through an existing IV line * identify drug, dosage and rationale in the recipient's dental record and on the claim form if filed as a paper claim * not allowed for drugs administered orally or drugs dispensed through the office or by prescription	No

DRAFT Proposed Amendments

5.3.12 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations

Dental providers may request special approval for a service that is non-covered by the NC Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid recipient under age 21. **All such requests must be submitted in writing prior to delivery of the service.** The request must include

- a. a completed two-part 2006 ADA claim form,
- b. any materials needed to document medical necessity (e.g., radiographs, photographs, a letter from the recipient's medical care provider), and
- c. the completed Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age) or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

Requests should be mailed to

**Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679**

If the procedure(s) receives special approval and the recipient is Medicaid-eligible on the date the service is rendered, the dentist then can file for reimbursement.

Note: A copy of the Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age) can be found on the EPSDT provider page. The Web address is specified below.

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

DRAFT Proposed Amendments

6.0 Providers Eligible to Bill for the Service

All providers participating in the Medicaid program must provide services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are made available at the time of provider enrollment.

7.0 Additional Requirements

7.1 Nursing Facility and Rest Home Charts

When providing dental services to a resident of a nursing facility or rest home, the recipient's chart at the facility must be documented by the dental provider with the date of service, the treatment provided, a plan of treatment or follow-up care, or an indication that no further treatment is needed. Filing a copy of the claim form in the recipient's record is insufficient documentation of treatment provided.

7.2 Postoperative Care for Residents of Nursing Facilities or Rest Homes

Providers are reminded that the fee for dentures includes six (6) months of post-delivery care. Visits to nursing facilities or rest homes should be scheduled in order to provide postoperative denture care in a timely manner.

7.3 Supplement to Dental Prior Approval Form (DMA 6022)

Prior approval for fabrication of a denture (impression, try-in or delivery) to be rendered in a nursing facility or rest home will be granted **only** if it is accompanied by a completed **Supplement to Dental Prior Approval Form (DMA 6022)**. The signature of the attending physician must be included. The facility is responsible for completing Section II of the form, securing the attending physician's signature, and retaining one copy of the form as part of the recipient's medical record. One copy is retained by the treating dentist and a third copy must be attached to the prior approval request form. This form is intended to assist in the review of denture requests by the EDS Prior Approval Unit, to determine medical necessity, and assess potential use of dentures by the recipient. Refer to **Attachment A – Dental Billing Guide** for additional information.

7.4 ~~Medicaid Post-payment Review~~

~~DMA Program Integrity (PI) works with the fiscal agent to conduct post-payment review of Medicaid claims. Dentists are reminded that patient records must be maintained on file for a minimum of five (5) years and available for the purpose of post-payment review. Providers must furnish a copy of treatment records requested by any authorized Medicaid representative. Providers cannot charge for records requested by Medicaid.~~

7.4 Medical Record Documentation

Providers are responsible for maintaining all financial, medical and other records necessary to fully disclose the nature and extent of services billed to Medicaid. These records must be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations or agreements. The provider must furnish upon request appropriate documentation, including recipient records, supporting material, and any information regarding payments claimed by the Provider, for review by the DMA, its agents, the Centers for Medicare and Medicaid, the State Medicaid Fraud Control Unit of the Attorney General's Office, and/or other entities as required by law. Providers cannot charge for records requested by Medicaid.

DRAFT Proposed Amendments

The North Carolina State Board of Dental Examiners applicable rule regarding patient records (21 NCAC 16T .0101) states that a dentist shall maintain complete treatment records on all patients treated for a period of at least 10 years. The complete Board rule regarding patient records is available for review at: <http://www.ncdentalboard.org/pdf/RulesRevised.pdf>

8.0 Billing Guidelines

8.1 Claim Form

Medicaid providers **must** use the 2006 ADA claim form. Refer to **Attachment A – Dental Billing Guide** for additional information.

8.2 Provider Numbers for Prior-approved Services

Individual Practice

Prior approvals granted to an **individual practice** are issued to the attending dentist's individual National Provider Identifier (NPI) and the individual Medicaid provider number. When filing a claim for payment for these services, the dentist must enter that individual NPI as the billing and attending NPI (fields 49 and 54) and that individual Medicaid provider number (field 52A and 58) on the claim form.

Group Practice

Prior approvals granted to a **group practice** are issued to the group National Provider Identifier (NPI) and the group Medicaid provider number. This allows any dentist enrolled with Medicaid as a member of that group to render the prior-approved services. Claims must be filed using the group NPI as the billing NPI (field 49) and the group Medicaid provider number (field 52A) on the claim form. Such claims also must include the individual NPI of the dentist who actually rendered treatment as the attending NPI (field 54) and the individual Medicaid provider number (field 58).

Note: Refer to **Attachment A – Dental Billing Guide** for additional information.

8.3 Copayment Amounts for Recipients

Medicaid recipients (except as listed below) are responsible for a \$3.00 copayment for each visit to the dentist. For services billed under one (1) procedure code, only one (1) copayment may be collected even if the procedure requires more than one (1) visit. The following categories of dental service are **exempt** from any copayment:

- a. services for individuals under the age 21
- b. services provided in a local health department
- c. services provided to Medicaid for Pregnant Women (MPW) recipients (pink MID card)
- d. services delivered in a hospital emergency department
- e. services provided to residents of nursing facilities, intermediate care facilities for mental retardation (ICF-MR), or state-owned psychiatric hospitals
- f. services provided to participants in the Community Alternatives Program (CAP)
- g. services **covered by both** Medicare and Medicaid

DRAFT Proposed Amendments

8.4 Billing of Medicaid Recipients

If a Medicaid recipient needs a dental service that is not covered by Medicaid, the provider should discuss this with the recipient **in advance** and handle any payments the same way as with a private pay patient. Medicaid recipients **may not** be billed for missed/broken appointments or for the difference between the billed amount and the amount paid by Medicaid or other third-party insurance carrier. Also, the provider **may not** bill the recipient when Medicaid denies payment because the provider failed to follow Medicaid policy.

8.5 Special Filing Instructions

8.5.1 Procedures Requiring a Tooth Number

Certain procedures require that a valid tooth number be entered in field 27 on the dental claim form. Absence of a valid tooth number will result in denial of payment for that procedure. **Attachment A – Dental Billing Guide** lists the procedure codes that require a tooth number as well as the tooth numbers that are valid for each procedure.

8.5.2 Supernumerary Teeth

The American Dental Association has determined that supernumerary teeth are to be coded based on the natural tooth space to which they are nearest. In the permanent dentition, use tooth numbers 51 through 82 beginning in the upper right third molar area and continuing around the upper and then the lower arches. In the primary dentition, an “S” is added after the normal tooth letter so that supernumerary teeth are numbered from AS to TS beginning in the upper right primary second molar area.

8.5.3 Procedures Requiring a Quadrant or Arch Indicator

Certain procedures require that a valid quadrant or arch indicator be entered in field 25 (area of oral cavity) or field 27 (tooth number) on the dental claim form. Absence of a valid indicator on the claim form will result in denial of payment for that procedure. **Attachment A – Dental Billing Guide** lists the procedure codes that require either a quadrant or arch indicator. Valid quadrant indicators are **UL** (upper left), **UR** (upper right), **LL** (lower left), and **LR** (lower right). Valid arch indicators are **UP** (upper arch) and **LO** (lower arch).

8.5.4 Procedures Requiring a Tooth Surface(s)

Certain procedures require that a valid tooth surface be entered in field 28 on the dental claim form. Absence of valid tooth surface(s) on the claim form will result in denial of payment for that procedure. **Attachment A – Dental Billing Guide** lists the procedure codes that require a tooth surface. Valid tooth surface codes are **M** (mesial), **O** or **I** (occlusal/incisal), **D** (distal), **F** or **B** (facial/buccal) and **L** (lingual).

8.5.5 Billing for Partial and Complete Dentures

Submission of a claim for payment indicates that all services on the claim have been completed and delivered. Therefore, claims for complete or partial dentures **must not** be filed until the date the appliances are delivered to the patient. Medicaid payment may be recouped for claims filed using a date other than the delivery date.

Note: If the recipient's Medicaid eligibility expires between the final impression date and delivery date, the provider should use the final impression date as the date of service. This exception is allowed **only** when the dentist has completed the final impression on a date for which the recipient is eligible **and** has actually delivered the denture(s). The delivery date **must** be recorded in the recipient's chart.

DRAFT Proposed Amendments

8.5.6 Billing for Nondeliverable Partial and Complete Dentures

Dentists should make every effort to schedule denture delivery **before** requesting payment for a nondeliverable denture. This must include contact with the recipient's county social worker who must be allowed at least two weeks to assist in scheduling an appointment for denture delivery. If a reasonable time has elapsed and circumstances beyond the dentist's control prevent denture delivery, then a claim for payment of non-deliverable dentures may be filed. The dentist must submit the following:

- a. A completed claim form clearly marked "**Nondeliverable dentures**"
- b. Any supporting material documenting the reason for nondelivery
- c. A copy of the lab bill indicating a charge for the dentures
- d. A copy of the dental record indicating dates and methods by which the recipient was notified and dates of any appointments for impressions or try-ins

These claims must be sent to

**EDS Prior Approval Unit
PO Box 31188
Raleigh, NC 27622**

Reimbursement is determined on a case-by-case basis. The dentist must retain the dentures, lab work orders, lab bills, and record documentation for five (5) years as proof that dentures were constructed. Dentures **must not** be mailed to Medicaid.

8.5.7 Billing for Clinic Dental Services

Dental services rendered at rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), local health departments or outpatient hospital dental clinics must be billed on the ADA dental claim form using CDT-2007/2008 dental procedure codes. These facilities should indicate "office" as the place of treatment (field 38). FQHCs must bill using the appropriate dental provider number designated by a "D" as the last or seventh digit. Services that require prior approval are handled in the usual manner as described in **Section 5.1, Prior Approval** regardless of the type of clinic/office setting.

DRAFT Proposed Amendments

8.5.8 Billing for Hospital Dental Admissions

Emergent or Urgent Dental Admissions

Emergent hospital admissions are necessary to prevent death or permanent health impairment for a Medicaid recipient. Urgent admissions are necessary when a recipient's condition requires immediate treatment that cannot wait for normal scheduling. Hospitals **do not** need prior approval for either emergent or urgent dental admissions. In form locator 14 on the UB-04 form, admission type "1" should be entered for emergent admissions and admission type "2" for urgent admissions.

Community Care of NC (Carolina ACCESS) Recipients

Hospitals must obtain authorization from the primary care provider (PCP) before admitting Community Care of NC (Carolina ACCESS) recipients for inpatient dental treatment. The PCP NPI referral authorization or the CA override number with the 1D qualifier must be entered in form locator 78 for paper claims on the UB-04 claim form. The PCP referral authorization must be entered in form locator 11 for electronic claims. The PCP name, address, and telephone number are listed on the recipient's Medicaid card.

Note: Dentists rendering services in an inpatient hospital setting must obtain prior approval for any dental service that requires prior approval.

8.5.9 Billing for Dental Treatment in Ambulatory Surgical Centers (ASC)

If a Medicaid recipient is physically unmanageable, medically compromised or severely developmentally delayed and will not cooperate for treatment in the dental office, treatment may be completed in an ambulatory surgical center (ASC). Dental providers enter "F" under place of treatment in field 38 on the 2006 ADA claim form. Services that normally require prior approval are handled in the usual manner.

Note: Anesthesia providers bill for services rendered in an ambulatory surgical center (ASC) using a CMS-1500 claim form. Refer to **Attachment A – Dental Billing Guide** for specific instructions.

Note: The ASC bills for facility use on a CMS-1500 claim form, which is priced based on total time of the case. Refer to **Attachment A – Dental Billing Guide** for specific instructions.

8.5.10 Billing for Assistant Surgeon Fees

Reimbursement for assistant surgeon fees will be determined on a case-by-case basis. A separate claim clearly marked "**assistant surgeon**" must be submitted along with the primary surgeon's claim. The assistant surgeon claim should list each procedure code in which the assistant participated. Both claims must be mailed to

**EDS Prior Approval Unit
PO Box 31188
Raleigh, NC 27622**

DRAFT Proposed Amendments

8.5.11 Billing for Services Covered by Both Medicare and Medicaid

Federal law mandates that Medicaid must be the payer of last resort when recipients are covered by both Medicare and Medicaid. According to the *Medicare Benefit Policy Manual* published by the Centers for Medicare and Medicaid Services (CMS), Medicare **does not cover** “services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth”. “‘Structures directly supporting the teeth’ means periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.”

Medicare Part B **does** cover certain oral surgical services performed by dentists or oral surgeons as long as they are not provided primarily for the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. Examples of Medicare-covered services include, but are not limited to, extractions in preparation for radiation therapy, reduction of jaw fractures, and removal of tumors of the jaw.

Services that are **not covered** by Medicare but are covered by Medicaid should be filed directly with Medicaid on the 2006 ADA claim form. Services **covered** by Medicare and performed either in the emergency room or in the office must first be filed with the Medicare Part B carrier using the CMS-1500 claim form. Refer to **Attachment A – Dental Billing Guide** for specific guidelines.

Note: For dually eligible Medicare/Medicaid recipients, dental services covered by Medicare **do not** require Medicaid prior approval.

DRAFT Proposed Amendments

9.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2002

Revision Information:

Date	Section Revised	Change
10/1/2003	All sections and attachments	Implementation of CDT-4 Procedure Codes and style/grammar revisions.
2/1/2004	Primarily sections 1.0 and 5.3	Conversion from CPT to CDT-4 codes for selected surgical dental services; other minor policy clarifications have been incorporated in this revision.
7/1/2004	5.3.4, 5.3.5, 5.3.10, 8.4.3, 8.4.5	Clarification of policy for codes D7280 and D7971; correction of minor typographical errors.
10/1/2004	5.0, 5.1, 5.3, 7.4, 8.0	Added or deleted selected procedure codes; revised descriptions and/or coverage limitations on selected procedure codes; revised billing guidelines; general revisions throughout the policy to improve clarity, grammar and style.
1/1/2005	Primarily sections 1.0 and 5.3	Implementation of CDT-2005 procedure codes.
2/1/2005	Section 5.3	Added procedure code D2933 that was inadvertently removed from the January 1, 2005 revision. Added statements regarding local anesthesia.
9/1/2005	Section 2.3, 5.3, and 5.3.12	A special provision related to EPSDT was added.
9/1/2005	Section 5.3.10	Added criteria for frenectomy procedure codes.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Section 2.3	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, 5.0, 8.5.6 and Attachment A12.	A note regarding EPSDT was added to these sections. Correction of typographical errors in section 8.5.6 and Attachment A12.
1/1/2007	Section 2.0, 5.3, 7.3, 8.5.6, and 9.0.	Added statement related to the Family Planning Waiver. Implementation of CDT-2007/2008 procedure codes. Revised coverage limitation for code D0320. Revised age limitation for sealants on primary teeth for procedure code D1351. Clarification of resin-based composite restorations policy. Added clarifying statements related to appliances and the Supplement to Dental Prior Approval Form (DMA 6022).
5/1/2007	Sections 2.3, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under age 21 years of age.
5/1/2007	Section 8.5.8	Added UB-04 as an accepted claim form.
6/1/2007	Section 5.3.12	Revised to include the Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age).
6/1/2007	Section 8.2 and Attachment A (Dental Billing Guide).	Revised billing guidelines and the Dental Billing Guide to include NPI and the 2006 ADA claim form.

DRAFT Proposed Amendments

Date	Section Revised	Change
	<u>Sections 5.3.1, 5.3.6, and 7.4</u>	<u>Added procedure code D0145; correct typographical errors section 5.3.6; deleted “Medicaid Post-Payment Review” information and replaced it with “Medical Record Documentation.”</u>

DRAFT Proposed Amendments Attachment A: Dental Billing Guide

A1. Instructions for Filing a Dental Claim

As of March 1, 2007, NC Medicaid began accepting dental claims on the 2006 ADA claim form. The following instructions are specific to that form.

Paper dental claims **must** be completed in black ink only (do not highlight any portion of the claim) to allow the fiscal agent to image all dental claim forms electronically. Providers wishing to file electronic claims must have an electronic claims submission (ECS) agreement on file. Contact the fiscal agent's ECS Department at 1-800-688-6696 for more information.

The following fields **must be completed as described** to allow proper processing of dental claims on the 2006 ADA claim form.

Field No.	Field Name	Explanation
12	Name	Enter the recipient's full name (Last, First, Middle) as it appears on the Medicaid card.
13	Date of Birth	Enter the recipient's date of birth using eight (8) digits (example: July 1, 2007 = 07012007).
14	Gender	Check the appropriate box: M=male, F=female.
15	Subscriber Identifier	Enter the recipient's 10-digit identification number listed on the Medicaid card.
23	Patient ID/Account #	Enter the recipient's medical record number if used by your office. This is optional but will appear on your Remittance and Status Report (RA), if entered.
24	Procedure Date	Enter the date the procedure was completed using eight (8) digits (example: July 1, 2007 = 07012007).
25	Area of Oral Cavity	Enter a valid code for procedures that require a quadrant or arch indicator in field 25 or 27.
27	Tooth Number(s) or Letter(s)	Enter a valid code for procedures that require a tooth number or letter.
28	Tooth Surface	Enter a valid code for procedures that require a tooth surface.
29	Procedure Code	Enter the five (5) digit dental procedure code rendered. Note: All procedure codes must begin with the letter "D".
30	Description	Enter the description of the procedure.
31	Fee	Enter your usual fee for the procedure, <u>not</u> the established Medicaid fee.
32	Other Fee(s)	If applicable, enter the amount of payment received from third party insurance plan(s). Do not include any payments from Medicare Part B or allowable Medicaid copayments.
33	Total Fee	Enter the total charges for all procedures listed on the claim form. Do not deduct Medicaid copayments or third-party insurance payments listed in field 32. The fiscal agent will calculate the maximum amount payable by taking into account any copayments or third-party payments.
34	Missing Teeth Information	Cross out (X) missing teeth, slash (/) teeth to be extracted, circle impacted teeth, and show space closure with arrows (←, →).
35	Remarks	Enter the billing provider's taxonomy.

Instructions continued on next page

DRAFT Proposed Amendments

A1. Instructions for Filing a Dental Claim, continued

Field No.	Field Name	Explanation
38	Place of Treatment	Enter the appropriate code (below) for the facility where the recipient was treated. Only one (1) place of treatment can be entered per claim. 3 = provider's office (or check box) 1 = inpatient hospital 2 = outpatient hospital F = ambulatory surgical center 4 = rest home or recipient's home 7 = intermediate care facility 8 = skilled nursing facility
48	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and zip + 4 code of the dentist or practice that is to receive payment.
49	NPI	Enter the billing provider's NPI number of the dentist or practice that is to receive payment. <ul style="list-style-type: none"> If payment is to be made to a group practice, then enter the group NPI number. If payment is to be made to an individual dentist, then enter the individual dentist NPI number.
52	Phone Number	Enter the area code and phone number of the billing dentist or practice.
52A	Additional Provider ID	Enter the Medicaid billing provider number. After NPI implementation, the Medicaid billing provider number is required for prior approval purposes only.
53	Signed (Treating Dentist)	Signature of the provider rendering service. The signature certifies that: "Services for which payment is requested are medically necessary and indicated in the best interest of the recipient's oral health. The provider's signature on Medicaid documents and claims shall be binding and shall certify that all information is accurate and complete." In order to submit claims without a signature on each claim, a "Provider Certification for Signature on File" form must be submitted to Provider Enrollment at EDS. The form is located at http://www.ncdhhs.gov/dma/Forms/pc.pdf .
54	NPI	Enter the attending provider's NPI number for the individual dentist rendering service. This number should correspond to the signature in field 53.
56	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and zip + 4 code.
56A	Provider Specialty Code	Enter the attending provider's taxonomy.
58	Additional Provider ID	Enter the Medicaid attending provider number for the individual dentist rendering service. After NPI implementation, the Medicaid attending provider number is no longer required.

Instructions continued on next page

DRAFT Proposed Amendments

A1. Instructions for Filing a Dental Claim, continued

Claims must be sent to

**EDS
PO Box 300011
Raleigh, NC 27622**

Claim forms may be ordered directly from the ADA.

<http://www.ada.org/ada/prod/catalog/index.asp>

Telephone: 1-800-947-4746

American Dental Association
Attn: Salable Materials Office
211 E Chicago Avenue
Chicago, IL 60611-2678

DRAFT Proposed Amendments

A2. Procedures Requiring a Tooth Number

The procedure codes listed below require a valid tooth number. Only the tooth numbers shown in the table are valid for the given procedure code.

Procedure Code	Valid Tooth Numbers
D1351	A, B, I-L, S, T, 2-5, 12-15, 18-21, 28-31
D2140	A-T, 1-32, AS-TS, 51-82
D2150	A-T, 1-32, AS-TS, 51-82
D2160	A-T, 1-32, AS-TS, 51-82
D2161	A-T, 1-32, AS-TS, 51-82
D2330	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2331	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2332	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2335	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2390	C-H, M-R, CS-HS, MS-RS
D2391	A, B, I-L, S, T, 1-5, 12-21, 28-32, AS, BS, IS-LS, SS, TS, 51-55, 62-71, 78-82
D2392	A, B, I-L, S, T, 1-5, 12-21, 28-32, AS, BS, IS-LS, SS, TS, 51-55, 62-71, 78-82
D2393	1-5, 12-21, 28-32, 51-55, 62-71, 78-82
D2394	1-5, 12-21, 28-32, 51-55, 62-71, 78-82
D2930	A-T, AS-TS
D2931	2-5, 12-15, 18-21, 28-31
D2932	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2933	C-H, M-R, CS-HS, MS-RS
D2934	C-H, M-R, CS-HS, MS-RS
D2940	A-T, 1-32
D2950	A-T, 1-32
D2951	A-T, 1-32
D2970	A-T, 1-32
D3220	A-T, 1-32
D3230	C-H, M-R

Procedure Code	Valid Tooth Numbers
D3240	A, J, K, T
D3310	6-11, 22-27
D3320	4, 5, 12, 13, 20, 21, 28, 29
D3330	2, 3, 14, 15, 18, 19, 30, 31
D3351	A-T, 1-32
D3352	A-T, 1-32
D3353	A-T, 1-32
D3410	6-11, 22-27
D5520	1-32
D5630	1-32
D5640	1-32, C-H
D5650	1-32
D5660	1-32
D7111	A-T, AS-TS
D7140	A-T, 1-32, AS-TS, 51-82
D7210	A-T, 1-32, AS-TS, 51-82
D7220	A-T, 1-32, AS-TS, 51-82
D7230	A-T, 1-32, AS-TS, 51-82
D7240	A-T, 1-32, AS-TS, 51-82
D7241	A-T, 1-32, AS-TS, 51-82
D7250	A-T, 1-32, AS-TS, 51-82
D7270	A-T, 1-32
D7280	A-T, 1-32
D7283	A-T, 1-32
D7971	A-T, 1-32

DRAFT Proposed Amendments

A3. Procedures Requiring a Quadrant or Arch Indicator

For the procedure codes listed below, a valid quadrant or arch indicator must be entered in the area of oral cavity (field 25) or in the tooth number (field 27). Only the indicators shown in the table below are valid for the given procedure code.

Procedure Code	Valid Quadrant/Arch Indicator
D1510	UR, UL, LL, LR
D1515	UP, LO
D4210	UR, UL, LL, LR
D4211	UR, UL, LL, LR
D4240	UR, UL, LL, LR
D4241	UR, UL, LL, LR
D4341	UR, UL, LL, LR
D4342	UR, UL, LL, LR
D5510	UP, LO

Procedure Code	Valid Quadrant/Arch Indicator
D5610	UP, LO
D5620	UP, LO
D7310	UR, UL, LL, LR
D7311	UR, UL, LL, LR
D7320	UR, UL, LL, LR
D7321	UR, UL, LL, LR
D7340	UP, LO
D7350	UP, LO
D7471	UP, LO

A4. Procedures Requiring a Tooth Surface(s)

The procedure codes listed below require a valid tooth surface(s).

Procedure Code	Valid Tooth Surfaces
D2140	M, I or O, D, F or B, L
D2150	M, I or O, D, F or B, L
D2160	M, I or O, D, F or B, L
D2161	M, I or O, D, F or B, L
D2330	M, I, D, F or B, L
D2331	M, I, D, F or B, L

Procedure Code	Valid Tooth Surfaces
D2332	M, I, D, F or B, L
D2335	M, I, D, F or B, L
D2391	M, O, D, F or B, L
D2392	M, O, D, F or B, L
D2393	M, O, D, F or B, L
D2394	M, O, D, F or B, L

DRAFT Proposed Amendments

A5. Example of a Completed Dental Claim

ADA Dental Claim Form

HEADER INFORMATION																																																																																						
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																																																																																						
2. Predetermination/Preauthorization Number																																																																																						
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																																																																																						
3. Company/Plan Name, Address, City, State, Zip Code																																																																																						
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																																																																																						
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, Jane R.																																																																																						
13. Date of Birth (MM/DD/CCYY) 12/02/1964				14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#) 123004567P																																																																																
16. Plan/Group Number				17. Employer Name																																																																																		
OTHER COVERAGE																																																																																						
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																																						
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		9. Policyholder/Subscriber ID (SSN or ID#)																																																																																		
9. Plan/Group Number		10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																						
21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																																																																																		
RECORD OF SERVICES PROVIDED																																																																																						
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description			31. Fee																																																																													
1 03/22/2007					D0120	Periodic oral evaluation			40.00																																																																													
2 03/22/2007					D1100	Prophylaxis—adult			85.00																																																																													
3 03/22/2007					D0274	Bitewing—two films			75.00																																																																													
4 03/22/2007			29	MC	D0302	Resin-based composite—two surfaces			175.00																																																																													
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34. (Place an 'X' on each missing tooth)																																																																																						
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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Primary				32. Other Fee(s)																																																																		
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35. Remarks XXXXXXXXXXXX																																																																																						
AUTHORIZATION																																																																																						
36. I have been informed of the treatment plan and associated fees. I am responsible for all charges for dental services and materials not covered by my dental benefit. I am prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out my treatment in connection with this claim.																																																																																						
X Patient/Guardian signature _____ Date _____																																																																																						
37. I hereby authorize and direct payment of the dental bill to be otherwise payable to me, directly to the below named dentist or dental entity.																																																																																						
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BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																																																																																						
48. Name, Address, City, State, Zip Code Dr. John Hancock 567 Any Street City, NC 27777-7777																																																																																						
49. NPI 9999999999		50. License Number 9101 333 - 0000		51. SSN or TIN 8992000																																																																																		
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52A. Additional Provider ID 8992000																																																																																						
ANCILLARY CLAIM/TREATMENT INFORMATION																																																																																						
38. Place of Treatment <input checked="" type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																																																																																						
39. Number of Enclosures (00 to 99) Radiograph(s) _____ Oral Image(s) _____ Model(s) _____																																																																																						
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																						
41. Date Appliance Placed (MM/DD/CCYY)																																																																																						
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																						
43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																						
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47. Auto Accident State																																																																																						
TREATING DENTIST AND TREATMENT LOCATION INFORMATION																																																																																						
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.																																																																																						
X John Hancock, DDS 03/25/2007 Signed (Treating Dentist) Date																																																																																						
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57. Phone Number (919) 333 - 0000																																																																																						
58. Additional Provider ID 8992000																																																																																						

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A6. Instructions for Submitting a Prior Approval Request

The following fields **must be completed as described** to allow proper processing of prior approval requests on the 2006 ADA claim form.

Field No.	Field Name	Explanation
12	Name	Enter the recipient's full name (Last, First, Middle) as it appears on the Medicaid card.
13	Date of Birth	Enter the recipient's date of birth using eight (8) digits (example: July 1, 2007 = 07012007).
14	Gender	Check the appropriate box: M=male, F=female.
15	Subscriber Identifier	Enter the recipient's 10-digit identification number listed on the Medicaid card.
25	Area of Oral Cavity	Enter a valid code for procedures that require a quadrant or arch indicator in field 25 or 27.
27	Tooth Number(s) or Letter(s)	Enter a valid code for procedures that require a tooth number or letter.
29	Procedure Code	Enter the five (5) digit dental procedure code. Note: All procedure codes must begin with the letter "D".
30	Description	Enter the description of the procedure.
34	Missing Teeth Information	Cross out (X) missing teeth, slash (/) teeth to be extracted, circle impacted teeth, and show space closure with arrows (←, →).
35	Remarks	Enter the billing provider's taxonomy.
38	Place of Treatment	Enter the appropriate code (below) for the facility where the recipient was treated. Only one (1) place of treatment can be entered per claim. 3 = provider's office (or check box) 1 = inpatient hospital 2 = outpatient hospital F = ambulatory surgical center 4 = rest home or recipient's home 7 = intermediate care facility 8 = skilled nursing facility
48	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and zip + 4 code of the dentist or practice that is to receive payment.
49	NPI	Enter the billing provider's NPI number of the dentist or practice that is requesting prior approval. If PA is to be issued to a group practice , then enter the group NPI number . If PA is to be issued to an individual dentist , then enter the individual dentist NPI number .
52	Phone Number	Enter the area code and phone number of the billing dentist or practice.
52A	Additional Provider ID	Enter the Medicaid billing provider number. After NPI implementation, the Medicaid billing provider number is required for prior approval purposes only.

Instructions continued on next page

DRAFT Proposed Amendments

A6. Instructions for Submitting a Prior Approval Request, continued

Field No.	Field Name	Explanation
53	Signed (Treating Dentist)	Signature of the dentist requesting approval. Prior approval requests require an original signature or signature stamp to certify that: "Services for which authorization is requested are medically necessary and indicated in the best interest of the recipient's oral health. The provider's signature shall be binding and shall certify that all information is accurate and complete." Approval constitutes only medical approval for services. Eligibility for care should be verified for the recipient for the month in which services are provided.
54	NPI	Enter the attending provider's NPI number for the individual dentist rendering service. This number should correspond to the signature in field 53.
56	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and zip + 4 code.
56A	Provider Specialty Code	Enter the attending provider's taxonomy.
58	Additional Provider ID	Enter the Medicaid attending provider number for the individual dentist rendering service. After NPI implementation, the Medicaid attending provider number is no longer required.

DRAFT Proposed Amendments

A7. Example of a Completed Prior Approval Request

ADA Dental Claim Form

HEADER INFORMATION																																																																													
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input checked="" type="checkbox"/> Request for Predetermination/Prior Authorization <input type="checkbox"/> EPSOT/Title XIX																																																																													
2. Predetermination/Prior Authorization Number																																																																													
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																																																																													
3. Company/Plan Name, Address, City, State, Zip Code																																																																													
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																																																																													
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Doc, John W.																																																																													
13. Date of Birth (MM/DD/CCYY) 01/09/1964				14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#) 123456789T																																																																							
16. Plan/Group Number				17. Employer Name																																																																									
OTHER COVERAGE																																																																													
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																													
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																													
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)																																																																									
9. Plan/Group Number		10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																											
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																													
PATIENT INFORMATION																																																																													
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other <input type="checkbox"/> Student Status <input type="checkbox"/> PTS <input type="checkbox"/> PTS																																																																													
19. Patient's Address (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																													
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																													
21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																																																																									
RECORD OF SERVICES PROVIDED																																																																													
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description			31. Fee																																																																				
1	UR				D4341	Periodontal scaling & root planing																																																																							
2	UL				D4341	Periodontal scaling & root planing																																																																							
3	LL				D4341	Periodontal scaling & root planing																																																																							
4	LR				D4342	Periodontal scaling & root planing																																																																							
5					D5214	Maxillary partial denture - cast metal																																																																							
6					D5214	Mandibular partial denture - cast metal																																																																							
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35. Remarks XXXXXXXXXX																																																																													
AUTHORIZATION																																																																													
36. I have been informed of the treatment plan and associated fees. I am responsible for all charges for dental services and materials not covered by my dental benefit plan, as prohibited by law, or the treating dentist's dental practice has informed me of my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the treatment and disclosure of my protected health information to carry out my treatment in connection with this claim.																																																																													
X. Patient/Guardian signature _____ Date _____																																																																													
37. I hereby authorize and direct payment of the dental benefit otherwise payable to me, directly to the below named dentist or dental entity.																																																																													
X. Subscriber signature _____ Date _____																																																																													
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																																																																													
48. Name, Address, City, State, Zip Code North Dental Clinic PO Box 1234 City, NC 27777-7777																																																																													
49. NPI 9999999999		50. License Number		51. SSN or TIN 7902222																																																																									
52. Phone Number (919) 555-5555		52A. Additional Provider ID		53. Additional Provider ID 7902222																																																																									
ANCILLARY CLAIM/TREATMENT INFORMATION																																																																													
38. Place of Treatment <input checked="" type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																																																																													
39. Number of Enclosures (00 to 99) Radiograph(s) _____ Oral Image(s) _____ Model(s) _____																																																																													
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																													
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42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																													
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47. Auto Accident State																																																																													
TREATING DENTIST AND TREATMENT LOCATION INFORMATION																																																																													
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.																																																																													
X. S.W. East, DDS _____ 04/01/2007 Signed (Treating Dentist) _____ Date _____																																																																													
54. NPI 9999999999		55. License Number																																																																											
56. Address, City, State, Zip Code North Dental Clinic P.O. Box 1234, City, NC 27777-7777		56A. Provider Specialty Code XXXXXXXXXXXX																																																																											
57. Phone Number (919) 555-5555		58. Additional Provider ID 8007766																																																																											

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A8. Example of a Voided Prior Approval Request

ADA Dental Claim Form

HEADER INFORMATION										POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)									
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input checked="" type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX										12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, John L.									
2. Predetermination/Preauthorization Number										13. Date of Birth (MM/DD/YYYY) 11/21/1961									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION										14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
3. Company/Plan Name, Address, City, State, Zip Code										15. Policyholder/Subscriber ID (SSN or ID#) 900600300B									
OTHER COVERAGE										16. Plan/Group Number									
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)										17. Employer Name									
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)										PATIENT INFORMATION									
6. Date of Birth (MM/DD/YYYY)										18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other									
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F										19. Student Status <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> PTS									
8. Policyholder/Subscriber ID (SSN or ID#)										20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
9. Plan/Group Number										21. Date of Birth (MM/DD/YYYY)									
10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other										Gender <input type="checkbox"/> M <input type="checkbox"/> F									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										Patient ID/Account # (Assigned by Dentist)									
RECORD OF SERVICES PROVIDED																			
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description										31. Fee			
1	UR				D4341	Periodontal scaling & root planing													
2	UL				D4341	Periodontal scaling & root planing													
3	LL				D4341	Periodontal scaling & root planing													
4	LR				D4341	Periodontal scaling & root planing													
5					D5214	Maxillary partial denture - cast metal													
6					D5214	Mandibular partial denture - cast metal													
7																			
8																			
9																			
10																			
MISSING TEETH INFORMATION																			
34. (Place an 'X' on each missing tooth)										32. Other Fee(s)									
X 2 3 5 6 10 11 13 14 15 X										A B C D E F G H I J									
32 31 30 28 27 25 24 23 22 21 20 19 18 17										T S R Q P O N M L K									
33. Total Fee																			
35. Remarks																			
XXXXXXXXXXXX BB 06-05-2007 EDS P.A. - Approved																			
AUTHORIZATION										ANCILLARY CLAIM/TREATMENT INFORMATION									
36. I have been informed of the treatment plan and associated fees. I am responsible for all charges for dental services and materials not covered by my dental benefit plan. I understand that the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out my treatment in connection with this claim.										38. Place of Treatment <input checked="" type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other									
X Patient/Guardian signature Date										39. Number of Enclosures (00 to 99) Radiograph(s) <input type="checkbox"/> Oral Image(s) <input type="checkbox"/> Model(s) <input type="checkbox"/>									
37. I hereby authorize and direct payment of the dental bill to be paid to me, directly to the below named dental or dental entity.										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)									
X Subscriber signature Date										41. Date Appliance Placed (MM/DD/YYYY)									
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)										42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)									
48. Name, Address, City, State, Zip Code										43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)									
North Dental Clinic PO Box 1234 City, NC 27777-7777										44. Date Prior Placement (MM/DD/YYYY)									
49. NPI 9999999999										45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident									
50. License Number 5555										46. Date of Accident (MM/DD/YYYY)									
51. SSN or TIN 7902222										47. Auto Accident State									
52. Phone Number (919) 555-5555										TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
53. Additional Provider ID 7902222										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.									
										X S.W. East, DDS 06/01/2007 Signed (Treating Dentist) Date									
										54. NPI 9999999999									
										55. License Number									
										56. Address, City, State, Zip Code									
										56A. Provider Specialty Code XXXXXXXXXXXX									
										North Dental Clinic									
										PO Box 1234, City, NC 27777-7777									
										57. Phone Number (919) 555-5555									
										58. Additional Provider ID 8007766									

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A9. Supplement to Dental Prior Approval Form (DMA 6022)

Available on the Web at <http://www.ncdhhs.gov/dma/formsprov.html#dental>

**NORTH CAROLINA MEDICAID PROGRAM
SUPPLEMENT TO DENTAL PRIOR APPROVAL FORM**

FULL DENTURE / PARTIAL DENTURE REQUEST

This form must accompany any prior approval request for full or partial dentures to be delivered in a long-term care facility (e.g., skilled nursing facility, intermediate care facility, adult care home).

I. PATIENT'S NAME LAST FIRST MIDDLE			BIRTHDATE (MM/DD/CCYY)	SEX	PATIENT'S MEDICAID ID NUMBER
II. THIS PORTION TO BE COMPLETED BY FACILITY STAFF					
FACILITY / ADDRESS / TELEPHONE NUMBER					
ATTENDING PHYSICIAN / TELEPHONE NUMBER			RELATIVE NAME / ADDRESS / TELEPHONE NUMBER		
DIAGNOSIS / PRIMARY / SECONDARY			MEDICATIONS		
PATIENT INFORMATION (Describe briefly)					
Level of disorientation: _____ Personal care assistance: _____					
Type of diet: _____ Activities/Social: _____					
Can patient communicate needs? _____					
Prognosis: _____					
Comments: _____					
Completed by: _____ Title: _____ Date: _____					
III. THIS PORTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN					
STATEMENT: IN MY OPINION THIS PATIENT IS ABLE TO TOLERATE DENTURES. THIS PATIENT DESIRES DENTURES. THIS PATIENT NEEDS DENTURES FOR AN IMPROVED QUALITY OF LIFE.					
_____ Attending Physician			_____ Date		
IV. THIS PORTION TO BE COMPLETED BY THE ATTENDING DENTIST					
STATEMENT: BASED ON ORAL EXAMINATION FINDINGS AND AN EVALUATION OF THIS PATIENT'S POTENTIAL TO UTILIZE DENTURES IT IS MY OPINION THAT DENTURES SHOULD BE PROVIDED. I WILL PROVIDE POST-OPERATIVE CARE FOLLOWING DENTURE INSERTION TO THE PATIENT AS NEEDED IN ACCORDANCE WITH MEDICAID GUIDELINES.					
_____ Attending Dentist			_____ Date		

DMA-6022 REV. 05/2004

DRAFT Proposed Amendments

A10. Billing for Anesthesia Services in an Ambulatory Surgical Center

Anesthesiologists and CRNAs bill for anesthesia services rendered in ambulatory surgical centers using a CMS-1500 claim form. Claims are paid based on total anesthesia time. Anesthesia time begins when the anesthesiology provider prepares the patient for induction of anesthesia and ends when the patient can be placed under postoperative supervision and the anesthesiology provider is no longer in personal attendance.

Providers must complete the CMS-1500 claim form as follows:

- a. Enter place of service code “24” in block 24B
- b. Enter CPT anesthesia code 00170 (*Anesthesia for intraoral procedures, including biopsy; not otherwise specified*) in block 24D
- c. Enter one of the following modifiers in block 24D
 - QX – services performed by CRNA with medical direction
 - QZ – services performed by CRNA without medical direction
 - QY – medical direction of one CRNA by an anesthesiologist
 - QK – medical direction of 2, 3 or 4 concurrent anesthesia procedures
 - AA – anesthesia services performed personally by anesthesiologist
 - QS – monitored anesthesia care (must be billed along with one of the modifiers listed above)
- d. Enter one of the following diagnosis codes in block 21
 - 140.0 – 145.9 230.0
 - 198.89 235.1
 - 210.0 520.0 – 529.9
 - 210.4 873.70 – 873.9
 - 216.0 947.0
- e. Anesthesia time in minutes is entered in block 24G on the claim form.

A11. Billing for Facility Charges by an Ambulatory Surgical Center

The ASC bills for facility use by filing a CMS-1500 claim form. These claims are priced based on total time for the case using one of the following groups:

<u>ASC Group</u>	<u>Total Time</u>
1	up to 30 minutes
2	31-60 minutes
3	61-90 minutes
4	over 90 minutes

Providers must complete the CMS-1500 claim form as follows:

- a. Enter place of service code “24” in block 24B
- b. Enter the dental procedure codes (CDT-2007/2008) for the services provided by the dentist in block 24D
- c. Enter modifier “SG” in block 24D
- d. Enter in block 24G the number of times each dental procedure code (CDT-2007/2008) was provided
- e. Enter the total operating room time in block 24
(example: “Total Surgical Time = 10:14 to 11:35)

Note: Only the dental procedure codes (CDT-2007/2008) listed in **Section 5.3, Procedure Codes and Limitations** are valid for billing in ASC cases.

DRAFT Proposed Amendments

A12. Billing for Services Covered by Medicare and Medicaid

The dental services listed below must be filed first with the recipient's Medicare Part B carrier on a CMS-1500 claim form. Typically, it is necessary to file such Medicare claims using *Current Procedural Terminology* (CPT) codes published by the American Medical Association.

D7285	D7441	D7710	D7860	D7945
D7286	D7460	D7720	D7865	D7946
D7288	D7461	D7730	D7870	D7947
D7410	D7465	D7740	D7872	D7948
D7411	D7490	D7750	D7873	D7949
D7412	D7540	D7760	D7910	D7950
D7413	D7610	D7780	D7911	D7955
D7414	D7620	D7810	D7912	D7980
D7415	D7630	D7820	D7920	D7981
D7420*	D7640	D7830	D7940	D7982
D7430*	D7650	D7840	D7941	D7983
D7431*	D7660	D7850	D7943	D7990
D7440	D7680	D7858	D7944	D7991

* denotes CDT-3 codes covered only for dates of service prior to 10/1/2003

For dates of service on or after 9/6/2004, claims paid by the Medicare Part B carrier will be crossed over automatically to Medicaid for payment – assuming the provider is set up for such automatic crossovers. Services will be reimbursed a specific percentage of the coinsurance and deductible based on the provider's type and specialty in accordance with the Part B reimbursement schedule established by DMA.

When a paid Medicare claim does not automatically cross over to Medicaid, the provider may submit the crossover claim directly to Medicaid using CPT codes on

- an 837 professional transaction with the coordination of benefits loop completed,
- an NCECS Web professional claim with the other insurance information completed, or
- a paper CMS-1500 claim with the Medicare voucher attached.

Note: Do not enter Medicare payments in block 29 of the CMS-1500 claim form. Only commercial insurance payments should be entered in block 29.

When the procedure(s) are denied by Medicare, the provider should submit the comparable CDT-2007/2008 code(s) directly to Medicaid on a paper 2006 ADA claim form with the Medicare voucher and Medicaid Resolution Inquiry form attached. This will allow the claim to process appropriately according to DMA policy. EDS is working on system changes to allow dental providers to file these overrides electronically using either the 837 dental transaction or the NCECS Web dental claim. Providers will be notified when those options are available.

Note: For specific guidance on (i) setting up automatic crossover of Medicare claims, (ii) filing crossover claims directly to Medicaid, or (iii) filing an override of denied Medicare claims, providers should contact EDS Provider Services at 919-851-8888 (Raleigh area) or 1-800-688-6696. EDS Provider Services also can give instructions on how to file claims for Medicare-covered procedures for dates of service prior to 9/6/2004.